

GENERAL INFORMATION:

This Excel file consists of 2 worksheets. Each worksheet is labeled as to its function.

If you are unable to see the tab for the worksheet across the bottom of the screen, click on the maximize button (the center button) located in the upper right-hand corner of the worksheet.

The worksheet is protected to prevent the changing of formulas and formatting features built into the spreadsheets.

You may submit completed forms in an electronic format or printed format. You must ensure that consumer information is protected as required by State and Federal law.

FOR ELECTRONIC FORMATS ONLY: If you submit this form to the regional center as an email attachment or on a CD ROM, use the following naming standard: Each file must start with the designation of "A" followed by the provider's three digit numerical designation and the month and year. See chart for month designations. For example: A372-JA04 is Form DS 1961 SEP for provider ID# 372 for January 2004.

FOR ELECTRONIC FORMATS ONLY: This form contains information protected under the Health Insurance Portability and Accountability Act (45 C.F.R Parts 160, 162 and 164). **The file must be password protected** to ensure the safety of the consumer's information. Coordinate with the regional center regarding protecting the consumer information contained in this form.

PROVIDER INSTRUCTIONS:*Provider Information*

Provider Name: Enter the name of the agency as vendored by the regional center.

Provider Number: Enter the agency's number provided by the vendoring regional center.

Check whether the report is the Initial report, an Annual report, or a Semi-Annual report and provide the date.

Address/City/ZIP: Enter the provider's business street address, city, and ZIP code. The business address should be the address the provider uses to conduct all its business activities. If the provider's business address is outside of California, list the two letter state abbreviation in the city field.

Phone: Enter the telephone number of the provider. Enter telephone number as XXX XXX-XXXX.

Supported Employment Program Consumer Information

Last Name: Enter the consumer's last name.

First Name: Enter the consumer's first name.

UCI: Enter the consumer's seven digit UCI #. **If the UCI # entered is less than or more than 7 digits, the field will remain light orange.**

SSN: Enter the consumer's nine digit SSN#. **If the SSN # entered is less than or more than 9 digits, the field will remain light orange.**

Supported Employment Program Objectives and Report on Consumer Progress

Work Objective #: Enter the work objective number.

Target Date: Enter the consumer's projected target date for completion of objectives. Enter date as mm/dd/yy.

First Six Month Period: Enter an "x" in the appropriate box during the first six month period whether the consumer met, partially met or did not meet his/her progression goals. Provide comments in the comment section on the consumer's progress.

Comments/Summary of Achievements: Provide comments on the consumer's progress. Also provide a summary of any achievements accomplished by the consumer.

Second Six Month Period: Enter an "x" in the appropriate box during the second six month period whether the consumer met, partially met or did not meet his/her progression goals. Provide comments in the comment section on the consumer's progress.

Comments/Summary of Achievements: Provide comments on the consumer's progress. Also provide a summary of any achievements accomplished by the consumer.

IPP Objective #: Enter the objective number from consumer's IPP (Individual Program Plan). Enter the objective title in the box after the IPP Objective #.

Behavior or Other Work-Related: Enter an "x" in the appropriate box if the objective is based on the consumer's behavior or other work-related issues.

Goal: State the goal of the objective.

Measurement: State what method the vendor will utilize to determine the consumer's progress.

Services for Objective: State the services that will be provided to meet the objective's goal.

Person Responsible: Provide the name(s) of the staff responsible for the objective services.

Current Functioning: State the consumer's current skill level related to the objective.

SUPPORTED EMPLOYMENT PROGRAM - GROUP SERVICES INFORMATION

Attendance %: Enter the percent of time the consumer attends work.

Productivity %: Enter the percent of time the consumer is productive at work.

Wages per Month (Six month average): Enter consumer's six month average of wages at work.

SUPPORTED EMPLOYMENT PROGRAM - INDIVIDUAL PLACEMENT INFORMATION

Percentage of Intervention: Enter the percent of time the consumer requires intervention during work.

Hours of Work: Enter the number of hours the consumer works.

Wages per Hour (Six month average): Enter consumer's six month average of hourly wages while working.

NOTICE

Read the notice and use the information to safeguard the consumer's information in accordance with the Health Insurance Portability and Accountability Act (45 C.F.R Parts 160, 162 and 164).

Consumer Signature: Have the consumer sign on this line.

Date: Enter the date the consumer signed the form. Enter date as mm/dd/yy.

Conservator Signature: Have the conservator or designated representative sign on this line.

Date: Enter the date the conservator or designated representative signed the form. Enter date as mm/dd/yy.

Continuation sheet (Additional Objectives Progress: Complete an additional worksheet for each objective as necessary.)

Supervising Staff Signature: The supervising staff person signs on this line.

Date: Enter the date the supervising staff person signed the form. Enter date as mm/dd/yy.

IHSP Participants: Indicate the names of the individuals who participated in the IHSP meeting.

Supported Employment Program Objectives and Report on Consumer Progress

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Month Designations:							
January	JA	April	AP	July	JL	October	OC
February	FE	May	MY	August	AG	November	NO
March	MR	June	JN	September	SE	December	DE